COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: PRIMARY CARE TAC MEETING

November 7, 2019
10:00 A.M.
Cabinet for Health and Family Services
Café Conference Room
275 East Main Street
Frankfort, Kentucky

APPEARANCES

L.M. (Mike) Caudill
PRESIDING

Chris Keyser
Promod Bishnoi
Raynor Mullins
Barry Martin
Yvonne Agan
TAC MEMBER PRESENT

David Bolt
Mary Elam
Noel Harilson
Teresa Cooper
Edward Conners
John Inman
Paula Straub
KENTUCKY PRIMARY CARE
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APPEARANCES
(Continued)

Carol Steckel
Jessin Joseph
Doug Oyler
David Gray
Judy Theriot
Sharley Hughes
Lee Guice
MEDICAID SERVICES

Pat Russell
WELLCARE

Christine Drake
Jessica Beal
PASSPORT

Chad Glass
Sammie Asher
AETNA BETTER HEALTH

Jennifer Smith
ANTHEM BCBS

Bethany Day
HUMANA-CARESOURCE

Nicole Allen
AVESIS

Michael Lin
FAMILY HEALTH CENTER
PHARMACY

Prentice Harvey
ATTORNEY AT LAW

Tracey Antle
CUMBERLAND MEDICAL
FAMILY CENTERS

Teresa Dotson
MOUNTAIN COMPREHENSIVE
HEALTH CORPORATION

AGENDA

1. Call to Order

2. Establishment of Quorum

3. Review and Approval of September, 2019 Meeting Transcript and Minutes

4. OLD BUSINESS:
   A. Report on wrap/crossover claims cleanup July 1, 2014 to June 30, 2018
   B. UB Modifier is not working as intended
   C. Setting 2020 PCTAC meeting dates
   D. Adding G0511 to the DMS fee schedule

5. NEW BUSINESS
   A. 340B Pharmacy Policy and Procedure Manual
   B. Free Care in Schools
   C. Nomination and vote for Vice-Chair of PCTAC
   D. PCTAC representation at MAC meeting 11/21/19
   E. Updates or announcements from MCOs
   F. Recommendations to the MAC

6. Adjournment

MS. KEYSER: It's about one minute after ten. We will get started. Thank you all for coming out today in this rain. I think we've got enough chairs for any others that might be coming to join us.

This is the Primary Care Technical Advisory Committee, November 7th. I call the meeting to order. We have established we have a quorum present of committee members.

Our first item up for business in our agenda is the nomination and vote for Chair and Vice-Chair of the Primary Care TAC. I need a motion for a nomination or nominations from the committee, please, for Chair and Vice-Chair.

MS. AGAN: I nominate Mr. Caudill as Chair and Chris Keyser as Vice-Chair of the Primary Care TAC effective today, 11/7/19.

MR. MARTIN: Second.

MS. KEYSER: There is a motion and a second for the nomination of Mike Caudill as Chair and Chris Keyser as Vice-Chair for the Primary Care Technical Advisory Committee. Are there any other nominations from the committee that should be considered?

There being none, then, all

those in favor of the Chair, Mike Caudill, and Vice-Chair, Chris Keyser, say aye. Those opposed. There being none, I now relinquish this meeting over to the new Chair, Mike Caudill, and we will switch places.

MS. HUGHES: For the record, can we assume that Mike Caudill is a new TAC member appointed by the Primary Care Association?

MS. KEYSER: Yes, ma'am, he is. Thank you.

MS. HUGHES: And while we are doing that because we do have a lot of new people apparently in the room today, could we do introductions. And also if people outside of the TAC members speak, could you give your name prior to speaking for our court reporter to be able to log who is saying what, please.

(INTRODUCTIONS)

MR. CAUDILL: Thank you. The previous meeting transcript for the September meeting was mailed out and provided on October 25, 2019. At this time, are there any comments, amendments or corrections to be made to that?

There being none, is there a motion to approve the transcript as mailed out?

MS. KEYSER: I'll make a

motion.

MR. CAUDILL: Motion made. Is there a second to that?

DR. MULLINS: Second.

MR. CAUDILL: Second by Raynor. All those in favor, say aye. All those opposed. Motion carries unanimously.

Under Old Business, the first order on that is a report on the wrap/crossover claims cleanup of July 1, 2014 to June 30, 2018 and to the current time.

As I understand, the Commissioner presented this last time, her draft of it as a proposal and asked that we provide feedback on that as to anything that we didn't like, anything that we liked or recommended amendments.

Is KPCA going to go forward on that?

MR. HARILSON: Yes.

MS. COOPER: The clinics continue to review and work towards a resolution on that with that document.

COMMISSIONER STECKEL: With yourselves?

MS. COOPER: Yes.

COMMISSIONER STECKEL: Okay, which means that they're waiting for the transition. So, that's fine. If that's the case, and I don't mean this the way it's going to sound, but we've all got a lot on our agenda. If that's the case, then, do we need to have this meeting?

MS. COOPER: No, we're not waiting on the transition. We're waiting for the clinics to review and come up with their calculations.

COMMISSIONER STECKEL: So, when is the next TAC meeting?

MS. HUGHES: January.

COMMISSIONER STECKEL: So, in essence, it will be the new Administration, and I'm not trying to be rude. I promise you all I'm not trying to be rude. It's just all of us have a lot on our agenda. If you all are not prepared at this point in time to respond, then, do we need this meeting?

MR. CAUDILL: Certainly this is one of the biggest issues for this but certainly it's also not the only issue to be talked about today.

COMMISSIONER STECKEL: Okay. Then we will go through the agenda, Mr. Chairman.

MR. CAUDILL: The next issue is the UB modifier which is not working as intended. And I believe at the last meeting, it was assigned to Ms. Guice to report back to us at this meeting.

MS. HUGHES: Let me see if I can get Lee here. I'll send an email to Lee. Can we move to the next item while we wait for her response?

COMMISSIONER STECKEL: I don't know why she's not here.

MR. CAUDILL: While you're trying to reach her, let's just go on, then. The next thing is setting future TAC meeting dates for 2020.

It is my understanding that Medicaid was wanting to move that up to a week in front of the MAC meeting and that it's currently on a two-week schedule, and the committee was thinking that two weeks was necessary to prepare their responses for presentation to the MAC.

So, is there any action that needs to be taken on that?

MS. HUGHES: You all have to set your dates, then.

MR. HARILSON: Have the MAC dates been set?

MS. HUGHES: The MAC always meets on the fourth Thursday except for November and it's the third Thursday.

MR. HARILSON: Sharley, do you have to have the specific date today?

MS. HUGHES: You all need to vote on the dates today.

MR. HARILSON: The specific date or can it be two weeks prior to the MAC scheduled meeting? Can it be phrased in that form or does it have to be a specific date and then we provide the specific dates at a later time?

MS. HUGHES: I'm just looking. If it ends up on days with other meetings. Like this week and next week, I've got ten TAC meetings. So, I'm trying to get away from having to do ten TAC meetings in five days.

COMMISSIONER STECKEL: But it's up to the committee. You make your dates and we'll put it on the calendar and we'll do what we can do.

MS. HUGHES: If you want to vote for it being two Thursdays before the MAC.

MR. MARTIN: We did talk about that, the second Thursday before the MAC.

MS. HUGHES: Right.

MR. MARTIN: Was there a problem with that date?

MS. HUGHES: I didn't look at the dates to see if there were others. It's your all's committee. The dates that I sent out were suggestions just trying to split some of the meetings up, plus I was trying to get rooms reserved early on before rooms started filling up.

So, those were strictly suggestions. You all can make it whenever you want to make it.

MR. MARTIN: Was there any reason to not have it on the second Thursday before the MAC?

MS. HUGHES: Other than just that there were other TACs going to be meeting on those days.

MR. HARILSON: So, for staff I think is what Sharley is saying, for staff's availability to be able to be present.

MR. MARTIN: The Thursday before the MAC is a little too quick. I think we agreed on that. What about the first Thursday of that month of the TAC, of the MAC?

MS. HUGHES: You can try for

that. It's whatever you all want.

MR. MARTIN: What do you guys think?

MS. AGAN: I would think that we want to go with the first Thursday of----

MS. KEYSER: We've got how many weeks from this meeting to when the MAC meets? Is that four weeks or is that two weeks?

MR. HARILSON: It's two weeks.

MS. KEYSER: So, right now we're at two weeks. This is our normal schedule. So, you are looking at----

MR. HARILSON: Three weeks, not closer but further away.

MS. AGAN: A week would be too close. Is three weeks too far out? I think the important thing here is to get members to attend.

MS. KEYSER: Right, so there's adequate representation. So, if we did three weeks before. Essentially, this meeting would have met last week.

MR. MARTIN: I'll make a recommendation that the months that the MAC meets that we meet the first Thursday of that month. I'll make a motion.

MR. CAUDILL: Is there a second to that?

MS. AGAN: I'll second it.

MR. CAUDILL: Motion made and seconded that future meetings will be on the first Thursday of the month in which the MAC meets. All those in favor, say aye. All those opposed. Motion carries unanimously.

MR. HARILSON: Sharley, I'll pull those dates and send them on to you so you don't need to look for them.

MS. HUGHES: Okay.

MR. CAUDILL: The next item under Old Business is the adding of G0511 to the DMS fee schedule; and according to my notes, Medicaid was going to respond to that at this meeting.

COMMISSIONER STECKEL: And Lee just walked in. Perfect timing.

MS. GUICE: Can you repeat the question?

MR. CAUDILL: It relates to the G0511 being added to the DMS fee schedule.

MS. HUGHES: Charles had said there was a reason that we could not add G0511.

MR. HARILSON: So, just for

context, if I may, Mr. Chair, Lee, if you recall, and you may not - that's why I'm trying to clarify a little bit - there had been some further detail that the PCA provided on behalf of the TAC to Medicaid about the reasoning for not only the UB modifier but the G0511.

And, so, both of those, Lee, is what we're looking at, the UB modifier not working correctly, and I remember you all had been working on that, you and Charles. At least you had reported that you all had been working on that UB modifier to mark for those claims to come in and not be triggered for a wrap when they're not wrap eligible.

MS. GUICE: Got it. Thank you, not be triggered for a wrap when they're wrap eligible.

MR. HARILSON: When they're not wrap eligible.

MS. GUICE: Or when they're not wrap eligible.

MR. HARILSON: And, then, the G0511 - correct me if I'm wrong, Teresa or Mary Elam - is a G code that's required by Medicare that the FQ's, at least the FQ's that I know of have to put on their claim. So, when it's hitting the MCOs, they're

denying that because it's not an accepted code for Medicaid but it's required for the FQ's to put on a bill for chronic care, for CCM.

And, so, the request was for Medicaid to add that as a non-payable code or however that terminology would be, so, as fee schedules are created from the Medicaid side as opposed to us having to go out to each MCO and ask them to configure that code on their own fee schedule.

MS. GUICE: Which they'll have to do as well.

MR. HARILSON: But it would be on the Medicaid fee schedule.

MS. GUICE: Sure. I was not aware that the UB modifier was not working as intended, though, 39, if my memory is serving correctly.

MR. MARTIN: It's been an outstanding issue since day one.

MS. GUICE: We intended to add a 39 to say if the UB 39 is on there, it doesn't fall into the wrap, whatever the UB modifier is.

MS. KEYSER: Right. So, this was at our last meeting and we discussed this. Those of us who are using a UB modifier, if the UB modifier

is not on every line item, then, the Medicaid system does not recognize they're not to pay the wrap on that.

We usually send the UB modifier on the office visit code, the 99213, and, then, the line item below it would be a CPT code for an administrative fee or whatever.

MS. AGAN: An injection.

MS. KEYSER: An injection, exactly. So, by putting the modifier on the office visit code, the 99211, our intention is to say that and anything associated with that visit is not wrap eligible but we are getting wrap payment on it.

MS. GUICE: But if you put it on every line item, it doesn't pay the wrap? Is that it?

MS. KEYSER: Teresa, can you help me with this?

MS. COOPER: Originally, the UB modifier was set up with two codes, the 99211 and the 99490.

MS. GUICE: Right.

MS. COOPER: My understanding at the last TAC meeting was that there was a change order that was written that was going to allow the

clinics to append the UB modifier to any code they felt should be a zero pay which would be vaccine administration code, injection administration code, anything like that.

MS. GUICE: Right, so that we wouldn't have to just----

MS. COOPER: It wasn't code specific.

MS. GUICE: Right.

MS. COOPER: We just haven't had an update of where that change order stands with DMS and DXC.

MS. GUICE: Okay. Thank you. That's a little bit easier. Sharley, the specific question when you want me to just come on down would be helpful.

MS. SHARLEY: I'm sorry. It was quickly sending you an email.

COMMISSIONER STECKEL: Stop. Move on.

MS. GUICE: I don't know the answer to that. So, I'll have to run upstairs and come back down.

MR. HARILSON: There's also a question from the committee on the G0511, too. So,

if you need to be able to get both of those.

MS. GUICE: Yeah. So, let me go upstairs. I'll leave my stuff here so you know I'm coming right back.

MR. CAUDILL: Okay. So, let's move on. We'll entertain her when she comes back. That's all the items under Old Business.

Under New Business, the first item is the 340B Pharmacy Policy and procedure Manual.

MR. HARILSON: We'll invite Mike Lin to the table.

MR. CAUDILL: All right. Mike, would you care to enlighten us on this?

DR. LIN: Good morning. I don't mean to bore you with a bunch of papers but I did want to bring up just a couple of things on this handout.

Mostly that health centers in Kentucky specifically and also across the country have a 24% lower spend for Medicaid than a non-health center patient, and health centers have a much larger percentage of Medicaid patients, as I'm sure you all are aware of.

The new 340B policy and

procedure as it's presented right now would seriously compromise the ability for health centers to generate revenue for themselves, specifically the 20 modifier which is a code that has to be attached to every prescription at the point of sale.

While some in-house pharmacies could do this, it effectively eliminates contract pharmacy which is when a health center or a covered entity has a contract with community pharmacy, it allows that community pharmacy to fill a prescription with 340B medication.

And since under the 340B program we are able to buy medications at a much lower rate than a traditional pharmacy would be able to, there's margin that's generated and, then, that margin is shared between the pharmacy, the TPA and the covered entity.

Well, none of the big chains can do this. Walgreens, Walmart, Kroger, CVS, none of them can do this. And because they cannot, that source of revenue is basically eliminated from the health centers.

I will speak for Family Health Centers myself, but this would be a complete shift for us. We would not be able to maintain business as

it is now without those funds.

I can say with a surety and I know that this may be a cry a lot of times from places that are having their funding reduced or their ability to produce revenue but we would have to close doors. Patients would not get serviced. The services that we provide would be drastically reduced.

Family Health Centers itself, we are an A site, a federally qualified health center in Louisville. We service roughly 42,000 individual patients. Of the eight clinics, I would almost guarantee you two of them will close.

And the whole reason I bring up the value that health centers bring, we're just one of 24 in Kentucky, and I can guarantee you that every single one that uses contract pharmacy will be drastically affected.

There are other options. Oregon has an option where they do it retrospectively. And I understand and I've had conversations that it would be difficult to accomplish here, but there are other ways of accomplishing the goal of preventing to do the discount, but the 20 modifier at this point is not

really a feasible one for the health centers.

MR. HARILSON: Any other comments?

MR. CAUDILL: This will be open up for discussion based on this, if the members or anyone else would like to comment on this.

MS. KEYSER: So, for clarification, DMS has presented a new policy and procedures and manuals for how 340B drugs should be used or documented and billed and things like that. Can I get a clarification?

MR. HARILSON: Do you want to give some more clarification on that?

DR. LIN: Sure. So, there was a policy and procedure that was presented and to take effect in January of 2020 that requires that all 340B claims that are submitted to the managed care organizations, the five MCOs in Kentucky must have that Level 20 claims modifier.

So, that's a manual process. When a claim is submitted or adjudicated through the pharmacy, that code has to be on that prescription. It's impossible at the contract pharmacies but it's also very difficult at in-house pharmacies because it's a manual process. It has to be done for every

single one.

MS. KEYSER: And that modifier is telling DMS or the MCOs what?

DR. LIN: So, it's telling the MCOs a couple of things. It's identifying it as a 340B drug. And, unfortunately, it also helps the MCOs or specifically the PBMs, the Pharmacy Benefit Managers for the MCOs, which CVS Caremark runs four out of the five in Kentucky, it tells them that we use 340B products.

And they, in turn, then, give us predatory contracts, contracts that they pay at such a low rate because they know we can----

COMMISSIONER STECKEL: And just for the record, you sign them.

DR. LIN: We have no choice. It's either take it or leave it type scenario. Yes, we do sign it. You are absolutely correct, Commissioner, but the problem is is that if we don't, then, we're out of all networks. We don't fill anything.

COMMISSIONER STECKEL: So, the FQHCs are safety net providers and we mandate that the MCOs must contract with safety net providers.

DR. LIN: That is correct, but

if they're going to give us a contract that's even less than what they would pay anybody else, that in itself is unfair.

And when we are submitting that modifier, it targets us specifically because then they can look at that and they can see, okay, Family Health Centers submitted 10,000 claims. Nine thousand nine hundred of them are 340B. Then, they classify us as a 340B pharmacy and, then, all our claims are paid at that predatory rate.

COMMISSIONER STECKEL: For which you sign that contract and you have power in that economic equation.

But let me add to this, and Jessin is welcome to chime in, this is bringing us into compliance with federal statute. 340B is a program to create low-priced drugs for a certain population. It's not to generate revenue for anybody. It's to create low-priced drugs for a certain population. Let me finish.

So, what we are doing with that modifier - and, Jessin, if I'm wrong, you jump in - is we're making sure that we are not having a situation where we are claiming a rebate and it's a 340B drug. There are lawyers lining up now to go

after Medicaid agencies. And when you start talking about critical damages, you're talking serious money.

The feds are paying attention to this, if you haven't read the headlines, and Congress, in one of the few things it's done, has taken $1.6 billion out of the 340B Program. They're not happy with the 340B Program and the advantages that providers of all types have taken of it.

So, I hear what you're saying. This brings us into compliance with federal law. So, I would suggest you talk to your Congressman and women.

DR. LIN: So, I don't disagree that Kentucky is somewhat late coming to the game with the compliance that's been set out by CMS, and I do agree that the program was designed to help patients of certain economic status, of which are the patients that we serve.

And I also don't disagree with you that we signed those contracts, but I think it's one of those Godfather scenarios where it's an offer we can't really refuse. There's no negotiation with the PBMs.

So, I would like to clarify that because we sign them voluntarily, so to speak,

but it's not that we have any other choice. They don't accept any red lines. They don't negotiate. And when they discover that we are a 340B which this modifier helps them do, Humana specifically will then force you to sign a 340B contract that is less than they pay anybody else substantially.

COMMISSIONER STECKEL: Do they pay you the 340B price, your acquisition cost?

DR. LIN: They are offering roughly the acquisition cost, sometimes less because it's a flat percentage across and the 340B price is flexible. It's not always a standard reduction off AWP or MAC.

DR. JOSEPH: So, those contracts, every contract that a PBM has in this state has to run through our office. We have not approved any contracts that discriminate against 340B.

So, the contract that any federally qualified health center gets in this state is the same contract that other pharmacies in this state get.

So, I think the concern has always been that they have the ability to do this, but we have made sure that they don't do this.

In terms of the Humana contract, I read the Humana contract. It is the same contract as the ones that's supplied to other pharmacies. So, there's no specific targeting towards 340B.

In terms of the submission clarification code of 20, it is right that we do require the 20 moving forward just some additional information on the procedures and policy manual. This was a proposed manual that came out on August 2nd of 2019 with an effective date of 10/1 and we opened it up for comments and feedback.

We actually extended the comment time deadline to October 3rd, so, just this last month, and we have complied all the comments and there are significant revisions that are occurring to it; but at the end of the day, we are still going to require the submission clarification code of 20.

We are extending the effective date from January 1, 2020 to 4/1/20. What this does is it allows systems really because the systems are the ones that are going to be able to handle the coding on this. So, if the system needs to be trained or bought or implemented, we are going to give ample time for that to occur.

But like the Commissioner said, CMS is asking us why we're not there. More than twenty-five states now in this country require what we're requiring. We're actually not requiring as much as some other states. We're only requiring the 20 and not the 08 and we're only applying this to CMS-1500 forms and the 837P form and not the 837I forms.

And, so, I think, again, when it comes to Medicaid dollars and manufacturers and rebates, there's a high amount of risk if we don't do this correctly. And, so, from the Medicaid standpoint, I think it's the right move for us to make sure that we are following federal law and, then, maintaining our Department as best as we can.

I guess the last thing I can add is the submission clarification code 20, as a point-of-sale, we do require it; but if a federally qualified health center or really any 340B-covered entity identifies that they sold a 340B-purchased drug after the point-of-sale, as long as it's within timely filing, they can reprocess that claim.

This way, when it gets back to our system and we go for rebate invoicing, we still have that 20 modifier on there.

So, as long as you know within timely filing, you can reprocess that claim. And there are a number of suggestions for us to reach out to other states. And one of the states that some 340B-covered entities asked us to reach out to was Texas and Texas actually does it the exact way that we're planning on moving forward with this.

So, I think that was the main concern was the timely filing and not knowing at point-of-sale; but, again, if you know after the point-of-sale, you can still reprocess that claim. We just need to make sure that when we invoice our manufacturers, that we are following it with exclusions of those with the 20 modifier on there.

DR. LIN: What is the reprocessing window?

DR. JOSEPH: It's the timely filing window, whatever is in your contracts, but I can't tell you off the top of my head.

MR. CAUDILL: I've heard what you've said here, but I think one of the original purposes was as a revenue-generated mechanism for----

COMMISSIONER STECKEL: Absolutely not.

DR. LIN: Financial viability

is one of the things that the 340B affords all covered entities. And whether or not it's----

COMMISSIONER STECKEL: Okay. If you all show us in the statute where it says it's a revenue-generating. It does provide for financial viability because it allows you to purchase drugs at a significantly lower rate than anybody else in the system, but it never was intended to be a revenue generator for any entity.

And you all are not the only ones that have figured out how to take advantage of this program which is why you're now putting the whole program at risk in Congress' eyes. Show me the statute. I'll stand down and I will apologize.

MR. CAUDILL: Let me also say that if you want to look at it, you were saying you all. FQHCs and RHCs are not the ones causing any problems in the program. Certainly there have been many articles about where allegations of abuse lies and it's not with the FQHCs and RHCs.

COMMISSIONER STECKEL: And I keep saying you all are not the only ones but you are taking advantage of a loophole and we're having to close that loophole because not only do we have lovely lawyers circling around hoping to make some

good money off of Medicaid by taking this on but we could get a disallowance from CMS, and CMS and Congress are looking at this issue.

MR. CAUDILL: Okay, and we don't need to dwell too long on this. Would anybody else like to make a comment who has not had a chance yet?

MR. HARILSON: Prentice, is there something that you wanted to say?

MR. HARVEY: Sure. I'm Prentice Harvey. I'm an attorney here in Frankfort, and as I previously said, I represent the Kentucky Primary Care Association as the Legislative and Executive Branch lobbyist.

I just want to ask a very fundamental question of why the policy manual is not being promulgated as an administrative regulation under KRS Chapter 13A?

DR. JOSEPH: It's not required to. This is a reporting requirement to the MCOs. So, we could theoretically go ahead and just put it in the MCO contract and not have any feedback period or comment period on it. We address it in the final comments and responses. So, I can send you the language.

MR. HARVEY: Can you give me some authority for that?

COMMISSIONER STECKEL: Yes. So, we'll go with our lawyers and we'll have our lawyers respond to you.

MR. HARVEY: Okay.

MR. HARVEY: Okay, because, to me, 13A is very clear----

COMMISSIONER STECKEL: Well, we disagree.

MR. HARVEY: ----that this affects private rights and that it needs to go through the 13A process.

COMMISSIONER STECKEL: If you will submit your question to me, I will get our lawyers to respond to you.

MR. HARVEY: I'll be happy to.

COMMISSIONER STECKEL: Delighted.

MR. HARVEY: Thank you.

MR. CAUDILL: Do you want to address the other issue?

MS. GUICE: So, what took me so long, and I apologize for that, is we're trying to track down exactly what Chris asked which was if you

put it on I guess the header, that it should apply to everything else on the claim. We were trying to track that down but we couldn't get that person to answer and respond right away.

So, that part I don't know, but, yes, the change order has been implemented. So, it should be working.

MS. KEYSER: For just those two codes.

MS. GUICE: No. For the modifier.

MS. AGAN: So, does that mean, Lee, that if you put that modifier on any CPT code, it should come through or are there a limited number of codes that it's available for use on?

MS. GUICE: No. We try to-- okay. Let me just make sure. Let me gather a little bit. Okay. So, as opposed to adding different codes, we determined that it would be easier to add a modifier, that if you put the modifier on any code means it's not eligible for the wrap. It would be zero pay for the wrap because, then, that way, we wouldn't have to continually add codes or change codes. We could address the solution once.

MS. KEYSER: But that's not

working.

MS. AGAN: Right. So, the next tier to that would be, so, does that mean that every code that is part of a PPS rate, would that have to have the UB? So, when you submit your 99211 with your UB and you did an administration code, do you still have to put the UB on that, also, and your drug codes or labs or anything else that you may be submitting on that one claim?

MS. GUICE: So, that's the part I couldn't confirm that I was trying to confirm upstairs with some folks at DXC to make sure that I could give you the correct answer. I can't give that to you now. I'll have to send that to you in an email.

MR. MARTIN: I guess the question would be is if you find that that is what is happening, can we have that fixed?

MS. GUICE: What you wanted to do is if you put it on the header, you want it to not pay for anything.

MS. KEYSER: Anything.

MS. AGAN: Anything on that date of service with that UB on there.

MR. MARTIN: The intent, I

guess----

MS. KEYSER: No. I mean, again, whether we do it one or the other, I think from what I'm hearing from my billers is they've tried it every which way and there is no consistency working with it. The claim goes to the MCO with the modifier. They pay the administrative code, the things underneath it. And, then, when it leaves them and goes to DMS and follows that claim, then, we still get a PPS with it.

MS. COOPER: Lee, what was the implementation date? Do you know?

MS. KEYSER: Because you are, too, aren't you?

MS. AGAN: Some of them do. Some of them don't. I can't figure out what the inconsistency is.

MS. GUICE: Okay. Can you send me an ICN of one that did and one that didn't and that way we could track and see what the differences are. Just send me an email.

MS. KEYSER: Mary, can I ask you a question? Did clinics not send you examples?

MS. ELAM: We did. We sent claims examples back in the summer with the ICN

number that did pay wrap that we felt should not have.

MS. COOPER: The change order was being written in September. So, it was implemented sometime between September and today. So, really, we need the implementation date to be able to look at claims after the implementation date to see if they're paying correctly.

MS. KEYSER: So, Mary, those clinics that were giving you that information, maybe if you send them something to say, hey, give us something more recent in that time frame and, then, we can get it to Lee.

MS. ELAM: Yes, ma'am.

MR. HARILSON: Can you find the implementation date?

MS. GUICE: I can. Obviously I didn't bring it.

MR. HARILSON: No, no. I'm just saying, so, when Mary does reach out, we can make sure that we're giving them a specific start date to the clinics to get those so they're valid examples for you.

MS. GUICE: Sure. I'm much more interested in one that paid correctly and one

that paid incorrectly.

MR. HARILSON: Okay. That's fine. I just wanted to make sure that we get them correct dates.

MS. GUICE: If we could look at kind of both of those to see what the----

MR. CAUDILL: So, this is information that was sent in July but we now need to update that to be information after the implementation date.

MS. KEYSER: Yes.

MR. CAUDILL: All right. Anything else?

MR. GUICE: The G0511, I don't think that there was a clear understanding from last time that we needed to add that to our fee schedule and why. So, we will do so now. We understand how Medicare pays it and what they do with it, that they pay it outside the PPS rate; but because we didn't have it on there, the MCO's, right. So, we'll add it and explain to them just that it's on there for no payment. It's a non-paid code. It's on there to be able to accept their encounters, period.

MS. AGAN: Do you have any time frame when that might occur or will you send us

notice?

MS. GUICE: It's probably not going to happen until January.

MR. HARILSON: Or whenever that's effective for January.

MS. GUICE: Yes.

MR. CAUDILL: All right. Then, let's go on to New Business, B, the Free Care in schools. Let me open that up to the committee for any comments they would like to address on that.

MS. AGAN: I think the big thing I'd like to just say about the Free Care, I think it sounds like a great program, but just talking, we need more information.

We need more of the details of how this is supposed to work, the coordination of care between the possibility of school-based care and that getting back to the primary care. What happens to these children during the summer months or when school is out? Will they have access to care?

We need more education on it. We need more information and the details of how this is going to work.

MR. CAUDILL: Can the Department comment on that?

MS. GUICE: Well, we've tried to design that program from our aspect of it as broadly as possible and that's why you probably don't feel like that you have very much structure to it.

And the reason we did that is so that our belief is that each individual school district has a separate set of needs that they know about that we don't know.

And, so, what we're trying to design is a way to get the claims in and the claims paid and that's all. That's all we're trying to help with.

The actual design of the program is going to be up to what services they offer, etcetera. It's going to be up to the individual schools.

Now, as far as data-sharing goes across the care providers, we're going to speak to the schools with the hope that their school data is going to be on KHIE and that you're going to be on KHIE and that you all can manage that way with the information on KHIE.

Are they going to offer services in the summer? That would be something that would not be up to us. And the SPA has been

approved.

COMMISSIONER STECKEL: What date effective?

MS. GUICE: August 1st.

COMMISSIONER STECKEL: And we agree with your concerns. We want to make sure that that child maintains a relationship with their primary care physician, provider, whatever.

So, we have talked to the school districts about that. We encourage you all. We know that there are a lot of FQHCs that already have robust relationships with the school districts and that's why, to Lee's point, we tried to design the program in a way that allowed whatever is happening to continue and now we put more revenue into the system or allowed for there to be more revenue.

But we have encouraged that relationship to make sure that particularly for special-needs children, children that have chronic conditions that they're tied back into their MCOs, they're tied back into their primary care system but that also is incumbent on you all. We encourage you all to work with your school districts.

This is a great opportunity to

do some innovations and that's what you all have always been about in communities, and we hopefully designed a program that allows you to be innovative working with the school districts. That's what we tried to do.

MR. CAUDILL: I think one of the concerns is is we're held responsible for these patients, both the medical loss ratio and the UDS and everything else and the ability to be able to find that information can be a very serious thing for us. We spend untold resources now trying to run down information just to be able to complete our requirements that's not all the time available to us.

MS. KEYSER: Well, you would like to think that if a child is seen by a provider in a school-based clinic system, that that visit and everything, that documentation would be sent to their PCP on their insurance card because, as you said, what they're getting basically is an acute care visit.

And for continuity, the PCP would sure like to know anything about that visit, particularly if a child is prescribed medication and things like that. So, that continuity certainly needs to be there, and I don't know, again, in each

school system whether there's a requirement or that's not on their radar. I don't know, but you are right in that we are held accountable for quality measures and reporting that kind of information but it requires somebody to give us that visit information.

MS. GUICE: So, one of the things that I would like to point out, the services that were provided in school-based services up until our SPA was approved were only services provided under the IEP.

And the IEP is governed by rules that come out of the Department of Education at the federal level, okay, and they have very strict rules about confidentiality of those services and what's provided in the IEP, period, and we have nothing to do with that and can't have anything to do with it.

These services are not under that program and, so, they should be considered as regular medical services. Okay? That's a point that's very important to take away from it. If you've been trying to get information about IEP's, you're not going to get it is what I hear. I'm not an expert on that. I just know that there are very strict rules about it, so, you're not going to get

that information, but this program is not under the regulation that the IEP's are under.

MS. KEYSER: So, if a child is in school and the school, I guess, offers we can do your well-child visit which, again----

MR. HARILSON: It would have to be correctly a licensed provider to be able to participate in this program. So, yes, they could do a well-child visit but it's not going to be an R.N. or a school nurse providing that service.

MS. GUICE: Right. I wouldn't think that the well-child visit is going to be something that's necessarily offered inside of a school setting without the school partnering with somebody in the community to provide that service. Okay? I just can't see the school system hiring an APRN to do well-child visits in their school. Okay? They could, though. They absolutely could.

MR. HARILSON: As well as behavioral health providers that are----

MS. GUICE: Absolutely. Absolutely.

MR. HARILSON: Can I ask a question?

MR. CAUDILL: Sure.

MR. HARILSON: You had mentioned that there would be a desire for them to have that information go into KHIE. Would that - and correct me if I'm wrong - would that mean that the school would have to have an EHR system to be able to connect to KHIE?

MS. GUICE: I can't respond to that. I don't know. You're out of my arena of expertise.

MR. HARILSON: I think that would be the case, and, so, it would be difficult for that information to go through KHIE if that----

MS. KEYSER: Without that, without it being electronic.

MR. CAUDILL: Any other comments?

MS. GUICE: We're trying to provide more access, not to impinge in any way. That's all this program is about.

MR. GRAY: And, Lee, those will be billed through Medicaid, right, not through the MCOs?

MS. GUICE: That's right. It's fee-for-service if the school is the billing provider.

MR. CAUDILL: We've already taken care of Item 6-C. Item 6-D is TAC representation for the MAC meeting that will occur on the 21st of this month.

MR. HARILSON: Are you able to be there?

MR. CAUDILL: If the good Lord willing.

MS. KEYSER: That would be our desire, I think, from the committee is for you to represent and report back. And in the event that you're not available, we can coordinate that.

MR. CAUDILL: Would you be available to also be there on that date?

MS. KEYSER: On the 21st, I will truthfully tell you I will be coming back from vacation and would not be able to get myself here. So, I regret at this time. In the future, probably yes, absolutely.

MR. CAUDILL: All right. So, I will be there. We will do MCO announcements. You have to work with me here. I don't know your faces yet.

MR. HARILSON: Let's start with Aetna.

MS. ASHER: Sammie Asher with Aetna.

MR. CAUDILL: Anything you would like to state or make an announcement on?

MS. ASHER: We don't have anything basically in the works right now. We're just getting through open enrollment and visiting some offices and getting some information out to the Assisters. So, that's been an adventure.

We're working with the UB modifier issue you guys are having that you're seeing across the board. We've sort of pinpointed it down on our side what had happened with that modifier. So, more to come on that.

That's about it. Do you all have any questions or any take-aways for me?

MR. CAUDILL: Thank you.

MS. SMITH: I'm Jennifer Smith with Anthem. Just a couple of things. I wanted to let you guys know that the 340B billing guidance has been sent out for Anthem. Also, we have our fall webinars coming up actually next week. So, hopefully if you guys are interested, you guys can jump on. They will be a webinar two days during the week next week, so, Tuesday, November 12th at 10:00 and

Thursday, November 14th at 2:00. So, hopefully you guys can join us. It will include all acts of business. And our territory maps have been updated and they're now available on our website.

MR. CAUDILL: Thank you.

MS. DAY: Beth Day with Humana and Humana-CareSource for about six more weeks and, then, we are going to be at the transition from Humana-CareSource to Humana.

We were at all of the MCO forums and at the KPCA conference blitzing everybody with our FAQ sheets that are available on our website and a list of all the changes that are effective 1/1/20.

One of the things that we are no longer using a PBM for our pharmacy benefits. It's going to be in-house with Humana and we are switching from Beacon and we're bringing behavioral health in-house as well. These are available on our website and great things to have at any of your billing desks, your registration desks.

And KPCA has been gracious enough to post those online for their clinics to be able to access as well if you all weren't able to pick up a copy at one of the forums.

We are working on a territory map and that should be posted before the end of the year. The new provider manual is available on the website. That's already up and running.

MS. KEYSER: Beth, can I ask you a question?

MS. DAY: Sure.

MS. KEYSER: In regard to the Beacon, so, what does that mean for providers who are in network and credentialed with Beacon as it transitions under your umbrella or whatever. Do they need to do something different?

MS. DAY: We recommend reaching out directly to Humana just to make sure that everything is carried over correctly. And in case it has not, that way we can expedite getting everything in place for you.

MS. KEYSER: So, if entities that currently are not under a Beacon contract and want to become a behavioral health and offer those kind of services, they don't have to do anything different if they're already under the Humana umbrella as a medical provider?

MS. DAY: They would need a behavioral health specific contract in order to

address that particular type of access.

MS. KEYSER: Okay. Thank you.

MS. AGAN: How are you preparing to make sure that the providers are all loaded and ready to go under this new setup January 1st?

MS. DAY: We have been working on that for some time now, many months, probably about as close to April when we found out this was happening. And since they manage the network, I feel like it's a lot easier piece because they already have the master data on the Humana side and they're loading off of that.

We have been working with providers and KPCA to sort of scrub the data and make sure that everything is clean for them to bump against to make sure that nothing was missed.

We've done a lot of provider data consolidation within the Humana-CareSource system that CareSource manages whereby if we found that for some reason historically over the years there were two different payee records that had exactly the same data, it really wasn't necessary to have two there. It didn't affect payment. It didn't screw anything up but we've consolidated that to

where there is only one master record, things like that. We've made sure that addresses are correct and still valid. We've done a lot of link-up to have everything as clean as possible when we launch so that you guys have a seamless transition.

MR. CAUDILL: Any other MCOs present today?

MS. DRAKE: Christine Drake with Passport. Just to let you guys know, definitely check our website for our E-News. Our latest is our Avesis vendor change effective 9/1/19. That is for routine and medical vision.

We do have our E-News published. Our territory map is out there as well and just let us know if you have any questions.

MR. HARILSON: And WellCare.

MS. RUSSELL: I'm Pat Russell with WellCare. Basically what we've been doing is getting out in the community with the providers and the members as we go through the open enrollment to make sure everybody is aware of what's going on, what hey need to do, what we will be doing and that kind of thing. So, ours has been primarily communication out with providers and members.

MR. CAUDILL: Is that it, then,

from the MCOs?

MR. HARILSON: Yes.

MR. CAUDILL: All right. Then, additional items for discussion.

MS. COOPER: One of the things that's been brought to the attention of KPCA is that FQHCs and RHCs are providing the same behavioral health services that are outlined in 907 KAR 15:050 and 15:010 with the same list of behavioral health providers. However, the TCM code is not billable for FQHCs and RHCs.

We would like to make the Department aware of that. We feel that TCM is an integral component of behavioral health and SUD treatment. And since we are allowed by the three regulations that govern us to provide the same services with the exact same provider, we would like to ask the Department to look at that.

COMMISSIONER STECKEL: If you will send it in writing, we will take it under consideration.

MR. CAUDILL: Any other additions?

The last item on the agenda is recommendations to the MAC.

MR. HARILSON: I would like to address the committee. Based on what we discussed on the agenda this meeting, I have taken out that we may want to have formal recommendations to MAC for the 340B discussion, as well as this new item of targeted case management.

So, we just formally put those out and then we can write them up and if the Commissioner requests, we can write them up and provide those to Medicaid, those formal recommendations.

MS. HUGHES: You will have to vote on the recommendations today. You would have to do the wording, what you want to say today. You can't just say we're going to vote on making a recommendation about TCM.

MR. HARILSON: That's not a problem. We can put something together here. Talk amongst yourselves while I do this.

MS. KEYSER: So, for the recommendation to the MAC, can it just be simply that the PCTAC recommends allowing FQ's and FQHC look-alikes to provide targeted case management for medical-assisted treatment and bill for that service?

MS. COOPER: I think we can

word it as the Primary Care TAC recommends allowing FQHCs, FQHC look-alikes and RHCs to provide targeted case management for behavioral health and SUD treatment.

Currently, the regulation regarding targeted case management for mental health or SUD, 907 KAR 15:050, does not authorize FQHCs, FQHC look-alikes or RHCs to provide the service. However, it does allow approved behavioral health practitioners and groups listed in 907 KAR 15:010 to provide targeted case management.

FQHCs, FQHC look-alikes and RHCs are authorized to provide behavioral health services by the same individual behavioral health providers outlined in 907 KAR 15:010 pursuant to Section 3 of 907 KAR 1:054 and 907 KAR 1:082 respectively.

The clinics use and employ the same type of providers enumerated as approved in the behavioral health practitioners for the targeted case management.

MR. MARTIN: Can we submit that?

MS. KEYSER: Is that sufficient?

MS. HUGHES: If that's your recommendation.

MR. MARTIN: We'll make that formal statement.

MR. HARILSON: I've got one here that I put together for 340B.

The Primary Care TAC recommends that DMS refrain from implementing the proposed 340B Policy and Procedure Manual and work with covered entities to find a solution to prevent duplicate discounts and allow the State to maximize their drug rebates.

In the alternative, the Primary Care TAC recommends delaying implementation of the manual to July 1, 2020 in order to coincide with the start of the new MCO contracts and allow covered entities to operationalize the required changes.

MR. CAUDILL: So, is that the two proposals, then?

MR. MARTIN: Do we need to make two motions or just one motion to accept both?

MS. HUGHES: You can make one motion for the recommendations.

MR. MARTIN: I'll make a motion.

MS. KEYSER: And I'll second that.

MR. CAUDILL: And Chris seconded it. Any other discussion? All those in favor, say aye. All those opposed, say nay. The motion carried unanimously.

And before we go to Number 6, let me say this. Thank you all for putting up with me on the first day of doing this. I know I kind of stumbled around and stuff but it will get better as we go on.

And, Commissioner and David, I want you all to know how much I appreciate the ability to meet with you all and to have these discussions here. I think this type of transparency is absolutely essential for all of us to achieve our purpose. So, thank you.

COMMISSIONER STECKEL: You're welcome. We agree.

MR. CAUDILL: Is there a motion to adjourn?

MS. KEYSER: Yes, sir.

MR. CAUDILL: We are adjourned.

MEETING ADJOURNED